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Somatic symptom disorder triggered by lifetime trauma: a case report

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CASE REPORT

Somatic symptom disorder triggered by lifetime trauma: a case report

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Abstract: Somatic Symptom Disorder (SSD) is characterized by persistent and distressing physical symptoms that cannot be fully explained by a medical condition. Cumulative lifetime trauma is a well established risk factor for SSD, often overlooked in traditional biomedical evaluations. **Objective:** To describe a complex case of SSD triggered by long standing psychological trauma and to highlight the diagnostic and therapeutic value of a trauma-informed, interdisciplinary approach. **Materials and methods:** A case of a 40-year-old Guatemalan woman with incapacitating chronic low back pain and multiple negative findings on structural and neurophysiological testing is presented. Her history revealed childhood physical abuse, a rape-related pregnancy, and prolonged intimate partner violence. Despite neurosurgical management, she reported a pain intensity of 9/10 on the Numeric Rating Scale (NRS), significant functional impairment, and depressive symptoms. A comprehensive psychiatric evaluation supported a diagnosis of SSD per DSM-5-TR criteria. She received psychoeducation, trauma-focused cognitive behavioral therapy, and graded physical rehabilitation. The rehabilitation program was designed and supervised by a licensed physiotherapist, focusing on progressive mobilization, core strength, and recovery of daily function. **Results:** After eight weeks of interdisciplinary treatment, the patient's pain level decreased to 5/10 on the NRS, PHQ-9 scores dropped from 18 (moderately severe) to 8 (mild), and she experienced a marked improvement in mobility and daily functioning. **Conclusions:** This case underscores the importance of identifying trauma as a central component in chronic pain syndromes. SSD remains underdiagnosed in trauma exposed populations, particularly in low resource settings. Early psychiatric referral and integrated care can prevent unnecessary interventions and improve long term outcomes.

Summary Box

- *This case highlights the clinical overlap between trauma related psychopathology and somatic symptom disorders.*
- *It illustrates how under-recognized trauma histories can delay diagnosis in chronic pain settings.*
- *The integration of psychiatry, physiotherapy, and pain medicine enabled functional recovery.*
- *Trauma-informed care reduced symptom severity and improved quality of life.*
- *This case underscores the need for interdisciplinary approaches in medically unexplained syndromes, especially in low resource settings.*

Keywords: Somatic Symptom Disorder; Trauma; Chronic Pain; Psychosomatic; Functional Syndromes

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Introduction

Somatic Symptom Disorder (SSD), as delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)[1] is characterized by one or more persistent somatic symptoms that result in clinically significant distress or functional impairment and are accompanied by excessive health-related thoughts, emotions, or behaviors.[2] The annual prevalence of SSD in primary care settings is estimated at 4–6 %.[2] Meta-analytic evidence indicates that exposure to traumatic experiences substantially increases the risk of chronic pain and functional somatic syndromes.[3-4] Proposed mechanisms include central sensitisation and dysregulation of neuroendocrine immune axes.[5] This case report illustrates how lifelong cumulative trauma can manifest as refractory chronic somatic complaints and situates the ensuing discussion within the contemporary literature. The next section details the patient's presentation and diagnostic work-up.

Case Presentation

A 40-year-old Guatemalan woman was admitted to a multidisciplinary pain clinic with a 12 year history of incapacitating low back pain. Her past medical history included two L4–L5 discectomies (2013 and 2017), a right hip fracture due to a motorcycle accident at age 22, and chronic sleep disruption. Despite appropriate neurosurgical care and pharmacological management, the patient reported persistent pain rated at 9/10 on the Numeric Rating Scale (NRS),[6-7] which significantly interfered with her mobility, occupational function, and quality of life.

The patient also disclosed a background of childhood physical abuse, intimate partner violence during adulthood, and a rape-related pregnancy at age 22. Repeated diagnostic evaluations, including magnetic resonance imaging (MRI), electromyography (EMG), and inflammatory markers, revealed no evidence of ongoing neuropathic or structural pathology. The discordance between the subjective severity of symptoms and the absence of objective findings prompted a referral to psychiatric services.

Psychiatric assessment revealed elevated health-related anxiety, catastrophic pain beliefs, and behavioral avoidance. These features, combined with the chronicity of symptoms, met the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria for Somatic Symptom

Disorder (SSD). Additional screening tools showed a Patient Health Questionnaire-9 (PHQ-9)[8-9] score of 18, consistent with moderately severe depressive symptoms.

The case illustrates the clinical relevance of trauma-informed screening in patients with medically unexplained symptoms. The profound functional impairment in the presence of extensive negative workups underscores the diagnostic value of early psychiatric referral in complex chronic pain syndromes.

Diagnostic Evaluation

The diagnostic process combined biomedical exclusion, standardized psychiatric screening, and clinical observation. Structural causes for the patient's pain were ruled out through serial magnetic resonance imaging (MRI) and electromyography (EMG), which showed no progressive discopathy, nerve compression, or signs of radiculopathy. Laboratory evaluations, including complete blood count, inflammatory markers (CRP, ESR), vitamin D, and thyroid function, were within normal ranges.

The patient described her pain as constant, burning, and disabling, with a baseline intensity of 9/10 on the Numeric Rating Scale (NRS). Despite pharmacologic therapy, she avoided physical activity due to fear of exacerbation and perceived spinal deterioration. These maladaptive behaviors contributed to a progressive reduction in mobility and increased healthcare utilization.

Psychiatric evaluation was performed using the DSM-5-TR criteria, supported by validated instruments. The Patient Health Questionnaire-9 (PHQ-9) yielded a score of 18, indicative of moderately severe depressive symptoms. While the Somatic Symptom Scale-8 (SSS-8)[10-11] was not available in her setting, the clinician's assessment and symptom report were consistent with high somatic symptom burden and significant psychosocial impairment.

Her presentation met all three core criteria for Somatic Symptom Disorder (SSD): (A) one or more distressing somatic symptoms, (B) excessive thoughts, feelings, or behaviors related to those symptoms, and (C) a chronic course lasting more than 12 months. These findings were documented and later summarized in a DSM-5-TR criteria table (see Table 1).

The integration of objective exclusion and subjective criteria facilitated a clear diagnostic formulation and prevented unnecessary repeat interventions.

Table 1. DSM-5-TR diagnostic criteria for somatic symptom disorder and clinical application

DSM-5-TR Criteria	Operational definition	Evidence in the patient
Somatic symptoms One or more somatic symptoms that are distressing or cause significant disruption of daily life	Chronic musculoskeletal pain that interferes with work, sleep, and activities of daily living for >10 years	Persistent low-back pain reported as "incapacitating," leading to occupational disability and fragmented sleep
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms (at least one of): • Disproportionate and persistent thoughts about symptom seriousness • Persistently high level of health-related anxiety • Excessive time and energy devoted to symptoms	Any one sub-criterion is sufficient; manifestations may fluctuate over time	Repeated consultations with multiple specialists despite unremarkable findings; pervasive worry about spinal "deterioration"; daily rumination and avoidance of feared activities
C. Chronicity The symptomatic state persists (typically >6 months)	Duration criterion differentiates SSD from transient somatic reactions	Pain has persisted for 12 years, with subjective worsening during the past year

Specifier: With predominant pain, persistent, severe applicable given the intensity, chronicity, and substantial functional impact of the pain complaint.

Therapeutic Intervention

The patient was enrolled in a multimodal treatment program designed to address both physical disability and trauma related psychopathology. Management was coordinated between psychiatry, physiotherapy, and pain medicine services. Treatment was delivered in an outpatient setting and followed a trauma-informed, stepped-care model.

Psychoeducation sessions conducted by a licensed psychiatrist focused on the biopsychosocial nature of pain and the influence of trauma on somatic perception. These sessions aimed to reduce catastrophic beliefs and promote adaptive coping strategies.

Trauma-focused cognitive behavioral therapy (TF-CBT) was initiated to address maladaptive cognitions and behavioral avoidance. Weekly sessions (60 minutes each) were conducted by a trained clinical psychologist.

Specific techniques included cognitive restructuring, graded exposure to avoided movements, and development of personalized relapse prevention strategies.

In parallel, the patient underwent graded physical rehabilitation, beginning with supervised low-impact aerobic activity (15–20 minutes of walking and core strengthening exercises, 3 times per week). Sessions gradually progressed in intensity and complexity over eight weeks, targeting functional goals such as stair climbing and domestic activity tolerance. The rehabilitation program was designed and supervised by a licensed physiotherapist, focusing on progressive mobilization, core strength, and recovery of daily function.

Pharmacologic therapy remained unchanged during this period, consisting of acetaminophen and low dose duloxetine (30 mg/day), prescribed previously for neuropathic pain and mood symptoms.

The patient was monitored weekly by the multidisciplinary team. Adherence was high, and no adverse events or exacerbation of symptoms were reported throughout the intervention.

This integrative approach prioritized functional restoration, psychological resilience, and trauma processing, aligning with current evidence supporting interdisciplinary care for somatic symptom disorders.

Results

At the conclusion of the eight-week intervention period, the patient exhibited clinically meaningful improvements across multiple domains. Pain intensity, initially rated at 9/10 on the Numeric Rating Scale (NRS), decreased to 5/10. This reduction was associated with improved tolerance to movement, reduced reliance on assistive devices, and gradual resumption of basic household activities.

The Patient Health Questionnaire-9 (PHQ-9) score declined from 18 (moderately severe depressive symptoms) to 8 (mild), indicating significant reduction in mood-related impairment. The patient reported fewer ruminative thoughts about her pain and a greater sense of control over symptom fluctuations.

Functional capacity improved, as evidenced by her ability to engage in low-intensity physical exercise without anticipatory fear or symptom exacerbation. Attendance at therapy sessions was consistent, and adherence to home exercise prescriptions was confirmed by both the physiotherapist and the patient.

There were no reported adverse events, medication changes, or pain flares requiring emergency visits or hospital admission during this time.

These outcomes suggest that the trauma-informed, interdisciplinary strategy contributed to both symptomatic relief and functional recovery.

Discussion

This case illustrates how cumulative psychological trauma can shape the clinical presentation, persistence, and severity of somatic symptomatology. The patient's history of early life adversity, sexual trauma, and intimate partner violence constituted a high-risk background for the development of SSD, in accordance with existing meta-analytic evidence linking trauma exposure to increased vulnerability for functional somatic syndromes.[3,12] From a pathophysiological perspective, chronic trauma alters the development and regulation of corticolimbic circuits, sensitizes descending pain modulation pathways, and disrupts the hypothalamic–pituitary–adrenal (HPA) axis.[13-14] These neurobiological changes lower the threshold for nociceptive perception and amplify bodily vigilance, thereby perpetuating somatic distress in the absence of identifiable pathology.

The diagnostic process in this case underscored the importance of structured psychiatric evaluation when faced with disproportionate pain reports and extensive negative findings. DSM-5-TR criteria[1] for SSD were met with clarity, and clinical scales such as the NRS and PHQ-9 provided objective benchmarks for symptom monitoring and response to treatment.

Therapeutically, the interdisciplinary model combining psychiatry, physiotherapy, and psychotherapy yielded substantial improvements in both functional outcomes and mood symptoms. This is consistent with stepped-care interventions shown to be effective in SSD.[15] The case also highlights the limitations of purely biomedical approaches and the potential harm of diagnostic delay or overmedicalization. Recent literature further supports this approach, highlighting the cost-effectiveness and clinical efficacy of interdisciplinary models in somatic symptom disorders.

Given the context of a low-resource setting, this case underscores the feasibility and impact of trauma-informed, collaborative care in the treatment of SSD. Table 1 summarizes the DSM-5-TR criteria and how they applied to the patient, offering a transparent framework for future replication and training.

Conclusion

Somatic Symptom Disorder remains under-recognized among trauma exposed patients, leading to diagnostic delay and potentially iatrogenic interventions. Routine, structured screening for lifetime trauma, including childhood adversity and intimate partner violence during chronic pain evaluations can uncover psychosocial drivers that purely biomedical assessments overlook. Early identification should trigger timely referral to mental health services and facilitate shared decision-making.

Interdisciplinary, trauma-informed care combining psychiatry, pain medicine, physiotherapy, and evidence-based psychotherapy has demonstrated superior diagnostic accuracy, functional recovery, and patient satisfaction compared with siloed, procedure focused approaches.[15] Implementing such integrated pathways is especially pertinent in resource-limited settings, where inefficiencies and repeat surgeries exacerbate patient burden.

Future research should prioritise pragmatic trials that evaluate stepped-care models and culturally adapted screening tools for SSD in low and middle income countries.

Informed Consent and Ethical Considerations

All identifying information has been anonymized to protect confidentiality. The report adheres to the CARE (CAse REport) guidelines and complies with institutional ethical standards for the publication of medical case studies.

Patient Perspective

The patient expressed that, for the first time in her care journey, she felt “listened beyond the pain.” She highlighted that understanding the psychological basis of her symptoms helped her reframe her suffering and regain a sense of control. She noted that psychoeducation and therapy sessions allowed her to release long standing feelings of shame and helplessness. She emphasized that having a multidisciplinary team validate her trauma history without judgment was a critical turning point in her recovery.

Equity, Diversity, and Inclusion Statement

This study considered gender informed approaches and trauma sensitive practices throughout the patient’s evaluation and care. The research team reflects a multidisciplinary and inclusive composition. Cultural

factors relevant to the Guatemalan context were integrated into treatment decisions, communication style, and follow up planning. The patient's socioeconomic background and limited access to mental health resources were taken into account when designing a feasible outpatient care pathway.

Conflict of interests

There are no financial, professional, or personal conflicts of interest related to the content or publication of this case report.

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